5-31-2008

Table to accompany Religion and Spirituality in Adjustment Following Bereavement: An Integrative Review

Jennifer H. Wortmann
University of Connecticut, jennifer.wortmann@uconn.edu

Crystal L. Park
University of Connecticut, Crystal.park@uconn.edu

Table 1 to accompany Religion and Spirituality in Adjustment Following Bereavement: An Integrative Review: Summary of studies with a quantitative assessment of religion and an adjustment outcome in bereaved participants

Author(s), Year Sample	Independent Religious/Spiritual Variable	Adjustment Variable	Results	Study Design
Amir & Sharon, 1982 126 widows of the Yom Kippur War; time post-loss approximately 2 years; demographic details not provided	Religious versus non-religious (question text not provided)	Functioning in the social-emotional, employment, relations with children, domestic, relations with Ministry of Defense, social activities, and mental areas	Non-religious widows functioned significantly better than religious widows only in domains of social-emotional, social activities, domestic, and relations with children.	Cross-sectional: questionnaire and interview (1x)
Anderson et al., 2005 57 mothers; M age=50.6; M time post-loss=4.5 years; loss of child to homicide or accident; 96.5% Caucasian; 73.7% Christian; from several national support groups	Coping Inventory for Stressful Situations (Endler & Parker, 1990) with task-, emotion-, and avoidance-oriented coping subscales; Religious Coping Activities Scale (Pargament et al., 1990) with spiritually based, good deeds, religious avoidance, interpersonal religious support (positive religious coping), pleading, and discontent (negative religious coping) subscales	Revised Grief Experience Inventory (Lev, Munro, & McCorkle, 1993)	Positive religious coping was associated with less grief only in those also using high levels of task-oriented coping, after adjusting for time post-loss and the main effects of the five coping styles alone. Negative religious coping was not significantly related to grief.	Cross-sectional: questionnaire (1x)
Austin & Lennings, 1993 57 Australian adults, 16% male; age range=18-75, M age=33; time post-loss within 5 years; "significant bereavement;" Christian or from a Christian background	Shepherd Scale measuring knowledge of Christian doctrine and degree of commitment to Christian beliefs (Basset et al., 1981); self-report questionnaire that included extent of religious belief and perceived helpfulness of religious beliefs in adjusting to bereavement	Beck Depression Inventory (Beck & Steer, 1987); Hopelessness Scale (Beck et al., 1974)	Knowledge of or commitment to Christian beliefs were not related to depression or hopelessness, but belief in the helpfulness of religion was correlated with less depression and hopelessness.	Cross-sectional: questionnaire (1x)

Bahr & Harvey, 1980 44 widows; median age=37; loss of husband in mining fire; time post-loss=6 months; Control group 1: 50 women; median age=36; married to survivors of same mining fire. Control group 2: 128 women; median age=35; married to workers in other area mines.	Religious involvement: religious intensity; participation in church social activities	Personal morale, measured by self-rated happiness ("Taken together, how would you say things are these days—would you say you are very happy, relatively happy, or not too happy?") and self-rated quality of life (Cantril ladder)	Religious social involvement related to higher quality of life, controlling for education and income, and religious intensity related to less unhappiness, controlling for education and age. More consistent positive influence of religion on widows than controls.	Cross-sectional with control comparisons: interview or survey (1x)
Baldewicz et al., 2000 159 adult homosexual men (90 HIV-1+, 69 HIV-1-); M age = 38; time post-loss=6 months; loss of close friend or intimate partner to AIDS; recruited from support group	Turning to religion subscale of the COPE (Carver, Scheier, & Weintraub, 1989)	Hamilton Rating Scale for Depression (Hamilton, 1960); Hamilton Anxiety Rating Scale (Hamilton, 1959); Profile of Mood States (McNair, Lorr, & Droppleman, 1971)	Higher scores on religious coping were negatively correlated with the confusion-bewilderment subscale and total mood disturbance of the POMS, but unrelated depression or anxiety, controlling for negative life events, social support, coping style, and health demographics.	Cross-sectional: survey and interview (1x)
Balk, 1991 42 adolescents, 60% female; age range=14-19; time post-loss=4-84 months; death by accident, illness, homicide or suicide	Attitudes toward religion: importance prior to loss, current importance, value of religion as a coping response, difficulty in believing	Grief reactions (emotional responses to death, persistent thoughts, suicidal ideation, effects on sleeping and eating, changes in intensity of grief, expectation whether grief would abate)	Importance of religion related to recalling more distress (i.e., fear, loneliness, trouble sleeping) after the death. Finding religion difficult to believe was related to more relief and less trouble eating after the death but more guilt and confusion currently. Finding religion valuable was related to more thoughts that grief feelings would endure and more trouble sleeping after the death, more dreams about the deceased but less depression after the death and at the interview, and fewer feelings of confusion at the interview.	Cross-sectional: interview with questionnaire (1x), retrospective

Bohannon, 1991 272 adults, 143 female; M age=38.2 for women, 39.8 for men; time post-loss=8-18 months; 229 Protestants, 33 Catholics, 10 with no affiliation	Church affiliation and attendance. Insufficient variability in affiliation (too few with no affiliation) to conduct analysis.	Grief Experience Inventory (Saunders & Mauger, 1979), including the following scales: despair, anger, guilt, social isolation, loss of control, rumination, depersonalization, somatization, death anxiety, vigor, physical strength, and optimism/despair	Attendance related to less death anxiety, anger, and guilt for men and women. For women only, attendance was negatively related to loss of control, rumination, depersonalization, somatization, and despair. Church attendance was not related to social isolation, vigor, or physical strength for either gender.	Cross sectional: survey (1x)
Bonanno et al., 2002 205 widowed adults, 180 women; M age=72 Changing Lives of Older Couples sample	Personal devotion (importance of religious/spiritual (R/S) beliefs, R service attendance, frequency of seeking S support, inclusion of religion/spirituality in decision-making) and religious conservatism (endorsing "born again," evangelism, inerrancy of Christian bible). (Items from Kendler et al., 1997, and Miller et al., 2000).	Center for Epidemiological Studies-Depression Scale (CES-D; Radloff, 1977); Bereavement & Grief Index (Jacobs et al.,1986); Present Feelings About Loss Scale (Singh & Raphael, 1981); Texas Revised Inventory of Grief (Zisook, DeVaul, & Click, 1982)	Participants were categorized into core bereavement patterns based on their depression and grief scores over time (Common Grief, Chronic Grief, Chronic Depression, Improved Bereavement, and Resilience). Personal devotion and religious conservatism were not related to the core bereavement patterns. Did not report a direct analysis of relations of religious variables with grief or depression.	Longitudinal and prospective: survey administered several years pre-loss (baseline), 6 & 18 months post-loss

Bornstein et al., 1973 65 widows, 19 widowers; M age=61; M time post-loss=13 months; white; 52% Protestant, 39% Catholic, 3% other Christian, 2% Jewish, 3% no affiliation	Church attendance pre-loss	Depression (low mood plus four of eight symptoms, including appetite/weight loss, sleep difficulties, fatigue, agitation, loss of interest, difficulty concentrating, guilt, suicidal ideation (from Feighner et al., 1972))	A significantly larger proportion of the depressed group had never attended church pre-loss (50%), compared with the non-depressed group (17%).	Cross-sectional (follow-up interview from an original study): interview (1x) Although the sample was "followed prospectively," the religiosity variables were only measured at 12 mos. post-loss.
Brown et al., 2004 103 widowed adults, 93 women; age range=38-92; 49% Protestant, 42.8% Catholic, 5% Jewish. Changing Lives of Older Couples sample	Change in importance of religion and religious/spiritual beliefs (single item); change in religious service attendance	19 grief items from the Bereavement Index (Jacobs et al., 1986), Present Feelings About Loss (Singh & Raphael, 1981), and the Texas Revised Inventory of Grief (Zisook, DeVaul, & Click, 1982); CES-D short form (Radloff, 1977); 10 anxiety items from the SCL-90R (Derogatis & Cleary, 1977); 5 subjective well-being items from Bradburn (1969); 2 insecurity items from face-valid measures from the CLOC study	Widows and widowers, especially those with high insecurity, whose importance of religious/spiritual beliefs increased over time, had lower grief scores at Waves 2 and 3 post-loss than those participants who did not increase importance. Change in frequency of attendance was unrelated to grief. Change in importance and change in frequency of attendance were unrelated to depression, anxiety, or subjective well-being. Controlled for gender, age, education, race, personality traits, self-esteem, locus of control, interpersonal dependency, as well as physical health and relationship variables.	Longitudinal and prospective: interview pre-loss (baseline), and 6, 18, and 48 months post-loss (Waves 1, 2, 3) (Used control group but did not assess whether religion was more important for widows than for non-bereaved.)

Cadell, Regehr, & Hemsworth, 2003 174 Canadian HIV/AIDS caregivers, 51.7% men, 46% women, 2.3% transgender; age range=19-79, M age=40.5; time post-loss=1 month-18 years	Spiritual Involvement and Beliefs Scale (Hatch et al., 1998): spiritual practices and principles, "higher power"	Growth (Stress-Related Growth Scale (Park et al., 1996); Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996))	Higher spirituality scores on the SIBS were related to greater latent growth variable, regardless of when the loss occurred. Controlled for social support, IES Intrusions and Avoidance (Horowitz, Wilner, & Alvarez, 1979), and depression (BDI; Beck, 1967).	Cross-sectional: questionnaire (1x)
Carey, 1977 78 widows, 41 widowers; median age=57, age range=28-70; time post-loss=13-16 months; white; primarily Protestant or Catholic. Control sample: 43 married women, 43 married men; median age=56, age range=36-77.	Intrinsic religiousness, affiliation	Depression (measure created for the study)	Intrinsic religiousness was not significantly related to adjustment for widows or widowers. Protestant and Catholic groups did not differ in depression scores.	Cross-sectional: interview (1x) (Used control group but did not assess whether religion was similarly related to adjustment for bereaved and non-bereaved.)
Cartwright, 1991 Relatives or close friends of 541 deceased adults; time post-loss=6-8 months	Strength of religious faith	Helpfulness of faith during bereavement; feelings of loneliness, coming to terms with the death	Strength of faith was positively related to perceived helpfulness of religion, but not to current feelings of loneliness or coming to terms with the death.	Cross-sectional and retrospective: interview (1x)

Clarke et al., 2003 438 adults, 334 females; M age=35, age range=18-88; time post-loss within 2 years; loss of grandparent, spouse, parent, friend, sibling, or other; many had also lost a parent prior to the two-year period; located by Compassionate Friends, hospices, churches, etc.	Self-rated religious intensity ("To what extent do you consider yourself a religious person?"); belief in life after death	Texas Revised Inventory of Grief (Zisook & DeVaul, 1983) ; Bereavement Experience Questionnaire – Revised (Guarnaccia & Hayslip, 1998); Affect Balance Scale (Bradburn, 1969); Coping Inventory (Horowitz & Wilner, 1980); Hopkins Symptom Checklist (Derogatis et al., 1974); self-report health measures (Rider & Hayslip, 1979)	Self-rated religious intensity was related to use of more coping behaviors, including spiritual/church-related coping (efforts to cope were considered an adjustment measure) and fewer health problems, but not to psychological symptoms grief, or positive or negative affect. Afterlife belief had no significant effect on bereavement adjustment.	Cross-sectional: questionnaire (1x)
Cook & Wimberley, 1983 145 parents, 90 females; loss of child to cancer or blood-disorder; 73% Protestant, 18% Catholic, 2 Jewish, 1 Greek Orthodox, 10 no affiliation. 114 parents in quantitative analysis: only those who informed a minister, priest, rabbi, or nun of the illness within two weeks of diagnosis, and included a religious service in the funeral arrangement.	Helpfulness of religious beliefs: "How helpful were your religious beliefs to your adjustment in that first year (after the death)?" Change in the strength of religious beliefs: "Would you say that your religious beliefs are now stronger than before your child's illness, or weaker, or about the same?"	Self-assessed adjustment, grief, and depressive symptoms.	Reporting helpfulness of religious beliefs was correlated with reporting an increase in strength of religious beliefs. Self-assessed adjustment, grief, and depressive symptoms had no significant correlation with change in strength of beliefs when controlling for demographic variables, time post-loss, surviving children, and length of illness. In qualitative analysis, religious commitment related to comfort in a theodicy of purposive death.	Cross-sectional: (1x) qualitative and quantitative, in-depth interview with both open and closed-ended questions (or questionnaire containing the same questions)

Davis, Nolen-Hoeksema, & Larson, 1998 205 adults, 74% female; M age=51.2; loss of loved one; 50% were primary caregiver; 30% Protestant, 28% Catholic, 4% Jewish, 2% New Age, 36% other San Francisco Bay area Hospices (same as Nolen-Hoeksema & Larson, 1999)	Possessing religious/spiritual beliefs: "Do you consider yourself to be religious or have a spiritual interest?"	Sense-making and benefit-finding ("Do you feel that you have been able to make sense of the death?" "Have you found anything positive in this experience?"); Inventory to Diagnose Depression (Zimmerman et al., 1986); State Anxiety Scale (positive affect) (Spielberger et al., 1970); general distress [sum of IDD, State Anxiety Scale, and PTS Scale]	Considering oneself to be religious or have a religious/spiritual interest (measured pre-loss) was positively related to having made sense of the loss at 6 months post-loss, and through this, was negatively related to distress at 6 months post-loss. Possessing religious/spiritual beliefs was not related to benefit-finding. Controlled for pre-loss optimism/pessimism, pre-loss distress, and age of the deceased at death.	Longitudinal and prospective: pre-loss, 6 and 13 months post-loss
Dimond, Lund, & Caserta, 1987 192 widows and widowers, 74% female; 107 (55.7 %) completed T1-T6; M age=67.6, age range=50-93; 73% Mormon The University of Utah Study	Affiliation: Mormon or non-Mormon	Life Satisfaction: LSI-A (Neugarten et al., 1961); Depression: Self-rating Depression Scale (Zung, 1965); single-item self-reports of physical health, coping ability, and stress	Mormons did not differ from non-Mormons on any of the five bereavement outcome variables. Controlled for sex, age, years married, SES, perceived stress, and social support.	Longitudinal: questionnaire (6x) 3-4 weeks, 2, 6, 12, 18, and 24 months post-loss
Easterling et al., 2000 85 adults, 77.6% female; age range=24-77, M age=50.9; loss of spouse, parent, child, or other loved one to various causes; M time post-loss=8 months; primarily Protestant (Scott & White Grief Study; same sample as Gamino, Sewell, & Easterling, 2000)	INSPIRIT (Index of Core Spiritual Experiences; Kass et al., 1991); church attendance	Grief Experience Inventory (Sanders et al., 1985); Hogan Grief Reactions Checklist (Hogan, 1995)	Higher spiritual experience scores were related to lower grief scores on both grief measures. There was no main effect for church attendance on either grief measure.	Cross-sectional: survey (1x)

Edmonds & Hooker, 1992 49 undergraduates; 30 females; M age=19; loss of immediate family member; time post-loss within last 3 years; 29% no religious affiliation	Change in cosmic meaning, including beliefs in God: "Is your belief in God or some higher power changing as a result of undergoing this experience? If so, how is it changing?"	Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979)	Self-reported change in beliefs in God (in a positive or negative direction) related to higher levels of IES.	Cross-sectional: survey (1x)
Faletti et al., 1989 181 adults, 65.2% female; age range=55-93; loss of spouse; time post-loss=2-8 weeks	Religious affiliation: Jewish (57.6%) or non-Jewish, including Protestant (20.9%), Catholic (16.9%), and other (4.6%)	Beck Depression Inventory (Beck et al., 1961); Hopkins Symptom Checklists (Derogatis et al., 1974)	Jewish participants scored higher on the BDI at all follow-up time points.	Longitudinal: questionnaire and interview (4x) 2-8 weeks and 7, 13, and 18 months post-loss
Fenix & Cherlin, 2006 175 adults, 131 women; M age=57; loss of spouse, parent, or other family member to cancer; primary caregivers; 57% Catholic, 25% Protestant, 7% Jewish, 7% other, 5% none	Summary score of "How religious do you consider yourself to be?", "How much is religion a source of strength and comfort to you?", "In general, how much do your religious beliefs and activities help you cope with or handle your loved one's loss?", "Do you belong to a church or synagogue?", and "How often to you attend church or synagogue?"	Major Depressive Disorder Module of the Structured Clinical Interview for the DSM-IV Axis I Modules (First, Spitzer, Gibbon, & Williams, 1996	Religiousness at baseline was significantly related to less depression 13 months post-loss, controlling for baseline depression, age, caregiver burden, and restriction on activities.	Longitudinal and prospective: interview (2x) pre-loss (37%) or within 1 month post-loss (63%), and 13 months post-loss
Folkman, 1997 156 adults; loss of partner to AIDS; primary caregivers. Control group: 97 non-bereaved caregivers. The University of California at San Francisco Coping Project	Religious/spiritual beliefs and activities (Folkman et al., 1992), including belief in higher self/God and use of meditation/prayer	Ways of Coping (Moskowitz et al., 1996); CES-D (Radloff, 1977); Positive States of Mind (Horowitz, Adler, & Kegeles, 1988); Affect Balance Scale (Bradburn, 1969)	Religious/spiritual beliefs and activities were related to more positive affect through positive reappraisals, and were correlated with problem-focused coping; however, the pattern was the same for caregivers whose partners did not die. From qualitative analysis, religious/spiritual beliefs provided comfort post-loss.	Longitudinal and prospective with control comparisons: 4 weeks pre-loss and 2 and 4 weeks post-loss

Frantz, Trolley, & Johll, 1996 312 adults and adolescents, 75% women; M age=40, age range=15-83; M time post-loss=13 months; 38% sudden death; loss of parent, spouse, grandparent, child, sibling, or other	Self-rated helpfulness of religious/spiritual beliefs: "To what extent and in what ways have any spiritual or religious beliefs you hold been helpful to you?"; "What aspects of your religion or your spiritual beliefs were of help to you in your time of grief?"	Perceived ability to cope with loss, optimism about future ("How well do you feel you've coped with the loss you've experienced? What degree of encouragement or discouragement do you feel about the future?")	Perceived helpfulness of religious beliefs was unrelated to perceived ability to cope but was positively related to optimism about the future.	Cross-sectional: interview (1x)
Fry, 2001 101 widows, 87 widowers; Canadian; age range=65-87; time post-loss=6-24 months	Importance of religion; participation in organized religion; spirituality (Spirituality Assessment Scale: Howden, 1992); comfort derived from religion (5 items adapted from Chatters, Levin, and Taylor, 1992); accessibility to religious support services ("How easy or difficult is it to get the help of your pastor, etc.")	Psychological well-being: a composite of measures for depression, anxiety, happy mood (following Ainlay & Smith, 1984; Bradburn, 1969; Holohan, 1988; Miller, 1976; Ryff, 1995)	For both widows and widowers, importance of religion, spirituality and practices, and accessibility to religious support were positively related to psychological well-being. For widows only, comfort from religion also positively related to psychological well-being. Participation in organized religion was not related to psychological well-being. Controlled for age, education, income, social support, negative life events, and health.	Cross-sectional: survey (1x)
Gamino, Sewell, & Easterling, 2000 85 adults, 77.6% female; age range=24-77, M age=50.9; loss of spouse, parent, child, or other loved one to various causes; median time post-loss=8 months; primarily Protestant (Scott & White Grief Study; same sample as Easterling, et al., 2000)	Intrinsic spirituality: INSPIRIT (Index of Core Spiritual Experiences; Kass et al., 1991)	Hogan Grief Reactions Checklist, including despair, panic, personal growth, blame/anger, detachment, and disorganization subscales (Hogan, Greenfield, & Schmidt, 2001)	Higher spiritual experience scores were related to higher personal growth scores, controlling for seeing some good resulting from the death and having a chance to say goodbye.	Cross-sectional: survey and semi-structured interview (1x)

Gass, 1987 100 widows; 98 Catholic; M age=71.3, age range=65-85; time post-loss=1-12 months; recruited with assistance from parish pastors (same sample as Gass, 1989)	Strength of religious beliefs (Assessment of Resources scale created for the study: 16 items including religious beliefs)	Sickness Impact Profile (Gilson et al., 1978) physical and psychosocial health subscales	Stronger religious beliefs significantly correlated with less psychosocial dysfunction but not with physical dysfunction.	Cross-sectional: interview (1x)
Gass & Lund, 1989 100 widows and 59 widowers; 157 Catholic; M age=71.3 for widows and 71.1 for widowers, age range=54-81; time post-loss=1-12 months; located through church burial records from Catholic parishes (same sample as Gass, 1987)	Strength of religious beliefs (Assessment of Resources scale created for the study: 16 items including religious beliefs)	Sickness Impact Profile (Gilson et al., 1978) physical and psychosocial health subscales	Stronger religious beliefs significantly correlated with less psychosocial dysfunction for widows, but there was no relationship between religious beliefs and psychosocial dysfunction for widowers. No relationship with physical functioning.	Cross-sectional: interview (1x) (same study as above, but examined effects by gender)
Ginzburg, Geron, & Solomon, 2002 85 parents, 46% males; M age=51; M time post-loss=31 months; loss of child to military operation or accident, road accident, suicide, or disease; participants in support group administered by Israeli Ministry of Defense	Religious attitudes: type of Jewish observance or non-observance: secular (55%), traditional (27%), or orthodox (18%)	Texas Revised Inventory of Grief (Faschingbauer, Zisook, & DeVaul, 1987): absent, delayed, prolonged, resolved grief; Symptom Checklist 90 (SCL-90; Derogatis, 1977); modified Psychosocial Adjustment to Illness Scale (PAIS; Derogatis & Lopez, 1983)	Type of grief was related to religious attitudes. Traditional attitudes were related to absent grief, which was related to impaired social functioning. Secular and orthodox observances were related to delayed grief, which was related to greater somatization, and to prolonged grief, which was related to less psychiatric symptomatology. Interactions between grief reaction and religious attitudes, controlling for level of education and circumstances of the event, were not significant.	Cross-sectional: questionnaire (1x)
Gray, 1987 50 adolescents, 34 female; age range=12-19; loss of parent to cancer, heart attack, or accident; time post-loss=6 months to 5 years	Presence of religious or spiritual beliefs	Beck Depression Inventory (Beck, 1967)	Presence of religious or spiritual beliefs correlated with lower depression scores. From the interview, a belief in the afterlife specifically was helpful in dealing with the loss.	Cross-sectional: interview (1x)

Hershberger & Walsh, 1990 29 widows and 20 widowers; age range=24-74, M age=51; time post-loss=6-25 months	Self-reported role involvements (including minimum monthly attendance at church); religiousness: self-reported religiosity, importance of religious beliefs, and involvement in a religious organization	Bereavement Adjustment Questionnaire (based on Carey, 1977 and 1979-80); Purpose-in-Life Test (Crumbaugh & Maholick, 1969)	Religiousness was significantly positively related to purpose in life, but not significantly related to adjustment, when controlling for sex, age, time post-loss, education, and income. The number of role involvements was significantly related to adjustment and purpose in life when controlling for other variables.	Cross-sectional: (1x) questionnaire
Higgins, 2002 621 parents, 70.5% female; age range=24-65+, 76.8% over 55; for 77%, time post-loss over 3 years; secondary analysis of the American Changing Lives Data Set	Belief in afterlife, church attendance	CES-D short form (Radloff, 1977)	Belief in afterlife and high frequency of church attendance negatively correlated with depression, but only frequency of attendance remained statistically significant when controlling for marital status, race, age, family income, and education.	Cross sectional: survey (1x)
Krause et al., 2002 304 Japanese adults, from sample of 1,723, 43% male; M age=69.17; time post-loss within last year; loss of family member or friend; from the National Survey of the Japanese Elderly	Private religious practices (pray, read scriptures, listen to or watch religious programs); religious coping; belief in afterlife (better place, eternal happiness)	Changes in hypertension (self-reported)	Belief in a positive afterlife at baseline, in combination with a death of a loved one predicted lower likelihood of reporting hypertension at the follow-up interview, controlling for baseline hypertension. Private religious practices and religious coping did not have a significant interaction with bereavement in predicting hypertension.	Longitudinal and prospective with control comparisons: interview (2x), 4 years apart
Levy, Martinkowski, & Derby, 1994 131 adults, 72% female; M age=60.7; loss of spouse to cancer; time post-loss=18 months; primarily Protestant Christian; from the Baltimore Bereavement Project	Spiritual support (from Maton, 1989)	Impact of Event Scale (Horowitz et al., 1979) intrusion subscale; CES-D (Radloff, 1977)	Spiritual support, related to fewer intrusions and lower depression scores over time.	Longitudinal: interview and questionnaire (4x) 6-20 weeks and 6, 13, and 18 months post-loss. IES completed bimonthly. Spiritual support measured at 13 months.

Longman, 1993 42 adults, 30 women; age range=19-83, M age=58; time post-loss=3 months-2 years; loss of a loved one in hospice; grief support group participants	Spiritual Perspective Scale, measuring "participants' perspectives of the extent to which they hold certain beliefs and engage in spiritually related interactions with others and "God" (Reed, 1986 and 1987)	Texas Revised Inventory of Grief (Faschingbauer, 1981) , unresolved grief	Spirituality was not related to unresolved grief at time 1 or time 2.	Longitudinal: questionnaire (2x) varied time post-loss, 3 months later
Lund et al., 1985 138 (72% of original sample of 192, completed T1 and T6 measures) widowed adults, 108 female; minimum age=50; 73% Mormon The University of Utah Study	(Frequency of) religious activity (never to once/week); Affiliation: Mormon versus non-Mormon	Coping Difficulties Scale (T6 Depression: Self-rating Depression Scale (Zung, 1965) converted into 1-7 equivalent; T6 single-item self-reports of coping ability and stress related to the loss on a 1-7 scale)	There was no difference between the poor coping group (n=25, summed score > 13) and the remainder of the sample, as assessed 2 years post-loss, in frequency of religious activity or affiliation, assessed 3-4 weeks post-loss.	Longitudinal: questionnaire (2x) 3-4 weeks and 2 years post-loss (T1 and T6 data from complete study)
Lund, Caserta, & Dimond, 1989 108 widows and widowers, 78.9% female, M age=67.6; used portion of larger sample (56.3% of bereaved) that completed all 6 interviews; approximately 72% Mormon; 85 non-bereaved controls The University of Utah Study	Affiliation: Mormon or non-Mormon	Subjective Well-Being, measured in 3 dimensions: Life Satisfaction (LSI-A: Neugarten et al., 1961); Depression (Self-rating Depression Scale: Zung, 1965); single-item self-reports of physical health	Mormons did not differ from non-Mormons on any of the measures of subjective well-being (life satisfaction, depression, or self-assessed health) in the bereaved and non-bereaved samples.	Longitudinal with control comparisons: questionnaire (6x) 3-4 weeks, 2, 6, 12, 18, and 24 months post-loss
Maton, 1989 81 adults, 62 female; M age=46.3; primarily white; loss of child; time post-loss within 2 years for “high life stress” group (n=33) and over 2 years for “low life stress” group (n=44); from Compassionate Friends groups	Spiritual support (rate accuracy of items: “I experience God’s love and caring on a regular basis;” I experience a close personal relationship with God;” Religious faith has not been central to my coping.”)	Hopkins Symptom Checklist depression scale (Derogatis et al., 1974); self-esteem scale (Rosenberg, 1965, adapted by Bachman & O’Malley, 1977)	For parents bereaved within 2 years, spiritual support was related to less depression and greater self-esteem, controlling for bereavement help group support, age, sex, and SES. No relationship for parents bereaved more than 2 years prior.	Cross-sectional questionnaire (1x)

Mattlin, Wethington, & Kessler, 1990 97 adults; married couples included in sample; M age=42; loss of loved one; time post-loss within one year	Religious coping ("How much did you rely on your religious beliefs to help you cope?")	Hopkins Symptom Checklist (Derogatis, 1977) anxiety and depression scales	Religious coping was most used by and most benefited people coping with the death of a loved one, as compared to other stressors. Religious coping significantly correlated with less depression and anxiety in bereavement situations, controlling for severity of the loss, severity of the threat, time post-loss, sex, age, and income.	Cross-sectional with control comparisons (people coping with other stressors): survey (1x)
McGloshen & O'Bryant, 1988 226 widows; age range=60-89, M age=71.6; time post-loss=7-21 months (M=13); Caucasian	Attendance annually at church/synagogue services (range=0-250, M=40.84, SD=50.49); participation annually in religious activities other than worship (range=0-160, M=6.85, SD=20.72); self-rated importance of religion	Affect Balance Scale (Bradburn, 1969)	After controlling for health, income, age, and educational level, frequency of attendance at worship services and other religious activities positively correlated with positive affect but unrelated to negative affect. Self-rated importance of religion was second only to health in strength of relationship with positive affect.	Cross-sectional: interview (1x)
McIntosh, Silver, & Wortman 1993 124 parents; 98 women; married couples included in sample; age range=15-40, M age=24.9; loss of child to sudden infant death syndrome; 97% Christian	Religious participation ("How often do you attend religious services?"); importance of religion ("How important is religion in your life?")	Perceived social support; cognitive processing of the loss; finding meaning in the death; SCL-90-R (Derogatis et al., 1976) shortened form; Affects Balance Scale (Derogatis, 1975); Bradburn Well-Being Scale (1969)	Greater religious service attendance, through social support and finding meaning, predicted greater well-being and less distress at 3 weeks and 18 months post-loss. Greater importance of religion, through increased cognitive processing, predicted greater distress at 3 weeks but less distress and greater well-being at 18 months post-loss.	Longitudinal: interview (3x) within one month, 3 months, and 18 months post-loss
Meert, Thurston, & Thomas, 2001 57 parents: 43 mothers, 6 fathers, 8 female guardians; age range 20-73, M age = 37; loss of child in the pediatric intensive care unit; M time post-loss 3.4 yrs	Coping Resources Inventory (cognitive, social, emotional, spiritual/philosophical, and physical) (Hammer & Marting, 1988)	Texas Revised Inventory of Grief (Faschingbauer, Zisook, & DeVaul, 1987)	Spiritual/philosophical coping was negatively correlated with early and long-term grief, but relationships were not significant in regression analyses.	Cross-sectional: questionnaire (1x)

Murphy et al., 2002 261 parents, 171 mothers, including 69 married couples; age range=32-61, M age=45; loss of child to accident, suicide, homicide, or vehicular homicide; from the Parent Bereavement Project (recruited for an intervention); primarily Caucasian (86%); 59% Protestant, 25% Catholic, 1% Jewish, 15% other affiliation	Religious coping (Turning to Religion subscale of the COPE (Carver et al., 1985)); engagement in family prayer; church attendance and change in first 2 years post-loss; use of pastoral/spiritual and private counseling	Brief Symptom Inventory (Derogatis, 1992); Traumatic Experiences Scale (to assess PTSD, developed by the investigator); acceptance of death	At 4 months post-loss, religious coping was positively related to acceptance of death for mothers only, and acceptance was related to less distress and PTSD symptoms. Church attendance and pastoral counseling were not related to mental distress, PTSD symptoms, or acceptance of death. The relationship between family prayer and outcomes was not reported. None of the religious measures were related to outcomes 5 years post-loss; however, participants appraised beliefs, faith, and prayer as having been helpful.	Longitudinal: questionnaire in small groups (2x) at 4 and 12 months and by mail (2x) at 24 and 60 months
Murphy et al., 2003 (At 5 years post-loss) 173 parents: 115 mothers, including 46 married couples; M age=47; loss of child to accident, suicide, homicide, or vehicular homicide; from the Parent Bereavement Project (recruited for an intervention); primarily Caucasian (86%); 59% Protestant, 25% Catholic, 1% Jewish, 15% other affiliation (same sample as Murphy et al., 2002)	Religious coping (Turning to Religion subscale of the COPE (Carver et al., 1985))	Brief Symptom Inventory (Derogatis, 1992); Marital Satisfaction subscale of the Dyadic Adjustment Scale (Spanier, 1976); self-rated physical health status; search for meaning ("Have you searched for meaning in your child's death as well as in your own life?")	Use of religious coping was related to having found meaning 5 years post-loss. Finding meaning was related to less mental distress, higher marital satisfaction, and better physical health.	Longitudinal: questionnaire in small groups (2x) at 4 and 12 months and by mail (2x) at 24 and 60 months

Nolen-Hoeksema & Larson, 1999 455 adults (n=313 at 13 months post-loss), 75% female; age range=20-86; loss of spouse, other relative, or close friend; 50% were primary caregiver; loss to cancer, AIDS, or other disease San Francisco Bay area Hospices (same sample as Davis et al., 1998)	Considering oneself to have a religious/spiritual interest; church/temple/synagogue attendance	Sense-making and benefit finding ("Do you feel that you have been able to make sense of the death?" "Have you found anything positive in this experience?"); Inventory to Diagnose Depression (Zimmerman et al., 1986); State Anxiety Scale (positive affect) (Spielberger et al., 1970); instrument for the study to gauge PTSD [IDD, State Anxiety Scale, and PTS Scale summed to create general distress score]; Hamilton Rating Scale for Depression (Hamilton, 1960); Life Orientation Test (Scheier & Carver, 1985); Coping Responses Scale (Moos & Billings, 1982); Response Styles Questionnaire, which assesses how participants tend to respond to their own symptoms of negative emotion, Ruminative Responses Scale (Nolen-Hoeksema & Morrow, 1991)	Having a religious/spiritual interest and regular attendance correlated with use of adaptive coping strategies and positive reappraisal. Religious/spiritual interests, attendance, and time had an interaction effect on depression: greater interest and at least occasional attendance related to lower levels of depression at 13 and 18 months. Religious/spiritual interest also related to making sense of the loss, even shortly after the loss. Religiousness measures had no significant relationship with the other psychological or physical distress measures.	Longitudinal and prospective: interview (4x) 1, 6, 13, and 18 months post-loss

Park & Cohen, 1993 96 undergraduates; 70 women; M age=19.56; loss of friend; time post-loss within last year; 46% Catholic, 54% Protestant	Religious Orientation Questionnaire (Feagin, 1964); Doctrinal Orthodoxy Questionnaire (Batson & Ventis, 1982); COPE (Carver et al., 1989); Religious Coping Activities Scale (Pargament et al., 1990); one-item estimation of religion's involvement in the coping process (after Park et al., 1990)	Beck Depression Inventory (1967); Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979); personal growth (1-item rating scale)	Intrinsic religiousness was negatively related to depression. Religious Pleading Coping was related to increased depression and event-related distress. Intrinsic religiousness was positively related to event-related distress, directly and through Religious Good Deeds Coping. Through Religious Spiritual Support Coping and attributions to a purposeful God, intrinsic religiousness was negatively related to event-related distress. Doctrinal orthodoxy was negatively related to distress through Religious Spiritual Support Coping. Intrinsic religiousness, through attributions to a loving God and positive reinterpretation, and extrinsic religiousness were positively related to personal growth. Controlled for unfair death perceptions, locus of control, closeness of the relationship, religious denomination, and sex.	Cross-sectional: interview and questionnaire (1x)
Park, 2005 169 undergraduates; 121 women, 44 men, and 4 who did not identify gender; M age=19.2; loss of significant other; M time post-loss=5.8 months, all within past year; mostly Christian	Intrinsic scale of Age-Universal Intrinsic/Extrinsic Scale-Revised (Gorsuch & McPherson, 1989) The sample was fairly religious as measured by the intrinsic scale.	Appraisals and attributions (Park & Cohen,1993); items assessing discrepancy between global & situational meaning (designed for the study); meaning-making coping (positive reinterpretation scale of COPE; Carver et al., 1989) CES-D (Radloff, 1977); Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979); Satisfaction with Life Scale (Diener et al., 1985); Stress-Related Growth Scale, short form (Park et al., 1996)	Intrinsic religiousness was positively related to subjective well-being through meaning-making coping, and to stress-related growth, partially through meaning-making coping. For those bereaved within 4 mos., intrinsic religiousness was associated with more discrepancies in global and situational beliefs and goals, depressed mood, and intrusive and avoidant symptoms. For those bereaved over 8 months ago, intrinsic religiousness was no longer related to discrepancies and depressed mood and was negatively associated with intrusions and avoidance. Controlled for attributions to chance and to God.	Cross-sectional: interview and questionnaire (1x)

Park, 2006 98 college students, 25 men, 73 women; M age=19; loss of a close loved one within the past 2 years; M time post-loss=11.6 months; 40% Catholic, 47% Protestant, 9% none; 4% other affiliation	A-UI/E Scale Revised (Gorsuch & McPherson, 1989); Religious Coping Subscale of the COPE (Carver, Scheier, & Weintraub, 1989); Belief in Afterlife Scale (Osarchuk & Tatz, 1973); Dispositional Hope Scale (Snyder et al., 1991)	Stress-Related Growth Scale (Park, Cohen, & Murch, 1996)	Only extrinsic religiousness measured at Time 1 was related to stress-related growth at Time 2. The effect was unrelated to religious coping, even though use of religious coping at Time 2 was related to extrinsic (and intrinsic) religiousness.	Longitudinal: questionnaire (2x) 11.6 months post-loss and 1 month later
Parkes, 1971/1972/1975 68 widows and widowers; age=under 45; American; primarily white, Catholic; 68 married controls, matched for sex, age, home location, family size, nationality, and occupational class. Harvard Study	Faith in God, regular attendance at church	Distress (acuteness, duration); e.g. disbelief, yearning for, idealization of, and preoccupation with the memory of the deceased.	Faith in God and regular attendance at church did not have significant relationships with outcome variables and were not predictive of outcome one year post-loss.	Longitudinal: interview (2x) shortly after and 1 year post-loss (Used control group but did not report whether religion was similarly related to adjustment for bereaved and non-bereaved.)

Pearce et al., 2002 265 adults at baseline, 164 at follow-up; 74% female; M age=62; M time post-loss=6.3 months; varied losses (90% spousal); 29 participants recruited through chaplain's office of hospital; 56% Catholic, 27% Protestant, 6% Jewish, 9% other, 2% no affiliation	Religious Coping Index (Koenig et al., 1992): "What helps you cope with the loss?" and "To what extent do your religious beliefs or activities help you cope with or handle the loss?"	Functional disability: 12-item subscale of the Established Populations for Epidemiological Studies of the Elderly (Cornoni-Huntley et al., 1993); chronic conditions (self-report); health promoting behaviors (self-report); mental health: SCID (Williams et al., 1992); social support: shortened form for the Interpersonal Support Evaluation List (Cohen et al., 1985); health service use (self-report); health costs	Higher religious coping scores correlated with more functional disability and less health service use at baseline but with improved health at follow-up, controlling for age, health, and health promoting behaviors. Lower religious coping scores correlated with decreases in health status at follow-up. Social support scores were not significantly higher for those with high religious coping scores.	Longitudinal: interview (2x) 6 months post loss with 4 month follow-up
Purisman & Maoz, 1977 25 mothers and 22 fathers (spouses), loss of son in war; time post-loss=2-3 years	Religious belief and traditional Jewish observance (measured by independent judges)	Adjustment measured by independent judges: sleep, appetite, health, guilt, blame, changed social and entertainment habits, difficulties at work	Religious belief and observance were not significantly related to adjustment. Suggest controlling for educational level.	Cross-sectional: semi-structured interview (1x)

Reed, 1993 181 adults and adolescents, 74% female; age range=15-82, M age=43.88; loss of immediate family member; time post loss about 10 months; loss by suicide or accidental death; 64.1% Protestant Christian, 19.9% Catholic, 9.9% no preference, 5.0% not specified, 1.1% Jewish (See sample for Sherkat & Reed, 1992)	Frequency of religious service attendance (1=Never; 4=Often); affiliation (0=Protestant; 1=Catholic)	Grief symptomotology (18 items, affective and cognitive responses) from the Grief Experience Inventory (Saunders & Mauger, 1979), the Positive Affect-Negative Affect Schedule, and items created for the study; detachment from family ("The death has brought my family closer together" and "My family and I do less together now than before the death."); self-esteem (2 items from Rosenberg, 1965); expressive support (3 items indicating how actively share thoughts & feelings about loss)	Attendance related to less grief, through greater self-esteem and expressive support, and to less detachment from family through greater expressive support. Affiliation was unrelated to outcomes. Controlled for exercise, victim's age, survivor-victim attachment, mode of death, and survivor's sex, race, age, and education.	Cross-sectional: survey (1x)
Richards & Folkman, 1997 121 care-giving partners of men with AIDS; added interviews approximately 2 weeks and 4 weeks post-loss The University of California at San Francisco Coping Project	Making references during bereavement interview to spiritual/religious beliefs, experiences, rituals, social support, and roles	Physical symptoms (20-item measure); CES-D (Radloff, 1977); positive morale subscale of the Affect Balance Scale (Bradburn, 1969); Positive States of Mind scale (Horowitz, Adler, & Kegeles, 1988); State Anxiety scale (Spielberger, 1988); State Anger Expression Inventory (Spielberger, 1988)	The group that made spiritual/religious references (54%) had greater depression and anxiety, lower levels of positive states of mind, and more reports of physical health symptoms than the group without spiritual references.	Cross-sectional: semi-structured interview (2x*) within first month post-loss *First interview assessed psychological well-being; second interview was unstructured

Richards, Acree, & Folkman 1999 70 care-giving partners of men with AIDS, from Richards & Folkman, 1997; time post-loss=3-4 years The University of California at San Francisco Coping Project	Making references during bereavement interview to new, old, and diminished beliefs, a continued relationship with the deceased, experiencing the deceased as a guide, and use of religiosity/spirituality to cope	Physical symptoms (20-item measure); CES-D (Radloff, 1977); positive morale subscale of the Affect Balance Scale (Bradburn, 1969); Life Orientation Test (Scheier & Carver, 1985); Positive States of Mind scale (Horowitz, Adler, & Kegeles, 1988); State Anger Expression Inventory (Spielberger, 1988); Religious or Spiritual Beliefs (Folkman et al., 1992): e.g. "believing in a higher self/God gives meaning to my life"	The group that made spiritual/religious references (77%) reported more religious/spiritual beliefs than the group without spiritual references. Other minimal effect sizes, but not significant relationships, were found: the group with spiritual/religious references had less anxiety, higher positive life orientation, and more reports of physical health symptoms.	Longitudinal: interview (1x) 3-4 years post-loss (continuation of above study)
Richardson & Balaswamy, 2001 200 widowers; around 60 yrs. old and above; time post-loss approximately 2 years, divided into less than or greater than 500 days post-loss	Reinvestment orientation (attendance at church social activities)	Affect Balance Scale (Bradburn, 1969)	Attending social functions at church was related to more negative affect among the early bereaved and less positive affect among the later bereaved, controlling for forewarning of death; whether the spouse died at home, needed medical care and suffered; whether the bereaved has a confidant and is dating; and the number of friends and extent to which the bereaved interacts with neighbors.	Cross-sectional: interview (1x)
Rosik, 1989 159 elderly widows (145, M age=63.8) and widowers (20, M age=68.3); time post-loss=0-168 months; recruited from support groups	Intrinsic-extrinsic religious orientation (Gorsuch and Venable, 1983)	Geriatric Depression Scale (Yesavage et al., 1983); Texas Inventory of Grief (Faschingbauer, DeVaul & Zisook, 1977)	Extrinsic religiosity and indiscriminate pro-religiousness (endorsement of items from both the intrinsic and extrinsic scales) were associated with more grief and depression for men and women. Intrinsic religiousness was not significantly related to depression or grief. Controlled for time post-loss, SES, and health pre- and post-loss.	Cross-sectional: survey (1x)

Rynearson, 1995 52 adults; 32 requested and 20 refused psychotherapy; time post-loss 1 year; loss of family member by homicide; Support Project for Unnatural Dying in Seattle	Religious faith (presence or absence, asked in interview)	Texas Revised Inventory of Grief (Faschingbauer, Zisook, & DeVaul, 1987); Revised Impact of Event Scale (Weiss & Marmar, 1995); Dissociative Experience Scale; death imagery survey	Lack of religious faith was associated with treatment seeking, and treatment seekers scored higher on grief, trauma responses, and intrusions.	Cross-sectional: interview and survey (1x)
Sanders, 1979-80 102 participants: parents (10 female, 4 male), children (27 female, 8 male), and spouses (38 female, 5 male); Control Group: 107 participants who had not experienced bereavement in the past 5 years, matched for sex and age, and married if matched to a participant who had lost a spouse	Church attendance (frequent: weekly or more often, infrequent: monthly or less)	Grief Experience Inventory (Sanders et al., 1976): denial, atypical responses, despair, anger, loss of control, somatization, death anxiety, loss of appetite, physical symptoms, optimism/despair, loss of vigor	Frequent church attendance was related to more optimism and appetite for the bereaved but not the controls. Attendance was not related to other outcomes.	Cross-sectional with control comparisons: survey (1x)
Sherkat & Reed, 1992 156 adults; loss of family member; loss by accidental death or suicide; Catholic or Protestant (other respondents eliminated from analysis) (See sample for Reed, 1993)	Church attendance, frequency of prayer and meditation; affiliation (Catholic=1 or Protestant=0)	18-item depression scale and 3-item self-esteem scale created for the study	Church attendance, through social support, was positively related to self-esteem (controlling for gender, race, age, marital status, education, mode of death, victim's age, and closeness to victim) but was not significantly related to depression when including social support in the model. Frequency of prayer was negatively related to self-esteem directly, but it was modestly positively related to self-esteem through church attendance. Catholicism was negatively related to self-esteem directly and through church attendance.	Cross-sectional: mailed survey (1x)

Siegel & Kuykendall, 1990 825 adults, 60% female; minimum age=65; 53% married, 47% widowed); 117 experienced the loss of non-spouse family member within the previous 6 months	Membership in a church or temple	CES-D (Radloff, 1977)	Lack of membership in a church or temple in combination with the loss of a loved one predicted higher depression scores, only for men and especially for widowers, controlling for sex, age, race, income, education, employment status, and self-rated health.	Cross-sectional with control comparisons: interview (1x)
Smith, Range, & Ulmer, 1991 121 adults and adolescents, 82.6% female; age range=16-86, M age 47.8; 1 month to 6 years 10 months post- loss of family member, primarily; loss by natural-anticipated or unanticipated death, accident, suicide, homicide; recruited from funeral homes and bereavement groups; primarily Catholic or Protestant Christian	Belief in Afterlife, Form A (Osarchuk & Tatz, 1973) The average score on afterlife belief was 4.3 out of 5.	Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979); Spiritual Well-Being Scale (Ellison, 1983); Social Provision Scale (Russell & Curtona, 1984); perceived recovery, imagine loved one returning, felt the death was not real, perceived acceptance of the death, experience of pain as a result of not making sense of the death	Higher afterlife belief was related to greater perceived recovery, less active avoidance of thinking about the death, and enhanced spiritual well-being, but not intrusions.	Cross-sectional: survey (1x)
Sprang & McNeil, 1998 171 adults, 54% women; M age=34; time post-loss=1-68 months, M time post-loss=28 months; loss of spouse, child, parent, sibling, spouse or partner to drunk-driving accident	Religious Scale (Bardis, 1961), including belief in supernatural being(s), doctrines, and behavioral requirements	Texas Inventory of Grief (Faschingbauer, DeVaul, & Zisook, 1977), measuring extent of mourning (grief at time of loss) and extent of grieving (grief at time of study); Mississippi Post-traumatic Stress Disorder scale (Keane, Caddell, & Taylor, 1987)	Religious beliefs and behaviors were related to less extent of mourning and grieving and fewer PTSD symptoms, when controlling for social support, subjective health status, gender, race, and marital status.	Cross-sectional: survey (1x)

Stroebe, W. & Stroebe, M., 1993 30 widows, 30 widowers; M age=53; time post-loss=4-7 months; non-bereaved control group of 30 married women, 30 married men; M age=53; contacts supplied by municipal registrars from 5 towns in southern Germany; Tubingen longitudinal study	Religious beliefs (including afterlife belief), religious habits (including attendance); scale constructed for the Tubingen study	German version of Beck Depression Inventory (Beck, 1967; Kammer, 1983); *Beschwerdenliste* somatic symptom checklist (von Zerssen, 1976)	No association was found between religious beliefs or habits with depression or somatic symptomatology, controlling for sex and marital status.	Longitudinal with control comparisons: interview and questionnaire (3x), 4-7, 14, and 24 months post-loss
Swanson, Pearsall-Jones, & Hay, 2002 66 mothers; age range=24-71, M age=43; time post-loss=2.5 months-41 years (M=12); loss of a twin or higher multiple to miscarriage, stillbirth, neonatal death, SIDS, drowning, illness, or suicide	Spiritual beliefs (retrospective and current; low to high levels)	"Do you sense a larger purpose for your twin's death?"; acceptance of circumstances of twin's death	Spiritual beliefs were significantly related to belief that the loss served a higher purpose and to acceptance of the loss.	Cross-sectional: survey and interview (1x)
Tarakeshwar et al., 2005 252 HIV-positive adults, 65.1% male; M age=40; time post-loss=1 month to 2 years; loss of loved one to AIDS; 71% African-American and Hispanic	Spiritual coping measured in prayer, belief, faith, and attendance; modified Coping with Illness scale (Namir et al., 1987)	Grief Reaction Index (Lennon, Martin & Dean, 1990)	Use of spiritual coping was significantly positively related to grief. Spiritual coping was more strongly positively related to grief for white (and among them, men more than women) than for ethnic minorities (and among them, women more than men), after controlling for social support, education, and sexual orientation.	Cross-sectional: survey (1x)

Tedlie Moskowitz, Folkman, & Acree, 2003 86 men with at least 3 years of post-bereavement data; loss of partner to AIDS; primary care-givers; gay or bisexual The University of California at San Francisco Coping Project	Religious/spiritual beliefs and activities: 10-item measure (Folkman et al., 1992)	CES-D (Radloff, 1977); Positive States of Mind (Horowitz, Adler, & Kegeles, 1988)	Religious/spiritual beliefs and activities were not significantly related to depression or positive states of mind at one month or predictive of CES-D or PSOM scores over 3 years, controlling for education, income, years in relationship, age, social support and other resources, positive and negative life events and other health stressors, and coping styles.	Longitudinal: interview (18x) 2 or 4 weeks post-loss, continuing bimonthly for 2 years and biannually for 3 years
Thearle et al., 1995 465 Australian adults, 258 female; loss of child to SIDS, neonatal death, or stillbirth; time post-loss=2 months; control group n=249	Frequency of church attendance generally and within past month	Anxiety and depression (instruments reported in "Early Parental Responses to Sudden Infant Death, Stillbirth or Neonatal Death," *Medical Journal of Australia*, 1991)	Regular attendance was related to less anxiety and depression regardless of whether they had lost a child.	Cross-sectional with control comparisons: interview (1x)
Thompson & Vardaman, 1997 150 adults, 86% female; M age=49.6, age range=23-74; loss of child (55%), sibling (18%), spouse (10%), or other relative (17%) to homicide; 90% African-American; primarily Protestant Christian; time post-loss=1.5-5 years, M=2.9	Religious Coping (Pargament, 1990), shortened to 24 items and specified for homicide: Religious Support, Pleading, Discontent, Deeds, Spiritually Based, and Avoidance coping subscales	Distress: Brief Symptom Inventory (Derogatis & Spencer, 1982); Post-traumatic stress: Civilian Mississippi Scale (Keane, Caddell, & Taylor, 1988)	Religious support coping was related to less distress but not related to post-traumatic stress. Pleading was related to more post-traumatic stress but not related to distress. Discontent was related to more distress and post-traumatic stress. Deeds were related to more distress but not related to post-traumatic stress. Spiritually-based and avoidance coping were not related to either distress or post-traumatic stress. Controlled for education and traumatic life event history.	Cross-sectional: interview (1x)

Uren & Wastell, 2002 109 Australian women; age range=22-49, M age=34.5; loss of child to stillbirth (78) or neonatal deaths (31); time post-loss=2-207 months	1 item on the helpfulness of spiritual beliefs in coping; Spiritual Orientation Scale (McIlwain, 1990), abridged, 6-item subscale measuring general spiritual beliefs (e.g. belief in and certainty of an afterlife; view of the material world; importance of spiritual beliefs; existence of spiritual meaning)	Perinatal Grief Scale (Potvin et al., 1989 and Toedter et al., 2001); Brief Symptom Inventory (Derogatis, 1993); Impact of Event Scale-Revised (Weiss & Marmar, 1995); 2 items (from Silver et al., 1983) on current search for meaning; 1 item on current meaning	Spiritual beliefs and perceived helpfulness of spiritual beliefs in coping were not related to grief directly, but they were negatively related to grief through having found meaning in the loss. Controlled for time post-loss, psychological distress, and sense of coherence.	Cross-sectional: questionnaire (1x)
Vachon et al., 1982 99 widows; M age=54, age range=27-69; loss of spouse primarily to chronic disease	Importance of religion	General Health Questionnaire (Goldberg, 1972)	Importance of religion was not significantly related to distress.	Longitudinal: interview and questionnaire (2x) 1 and 24 months post-loss
Walsh et al., 2002 95 adults of 129 at baseline, 65% women; M age=53; loss of relative (40% spouse or partner, 40% parent, 13% other) or close friend (7%) to terminal illness; recruited from palliative care center in London	The Royal Free Interview for Religious and Spiritual Beliefs (composite including religious/spiritual view of life; importance of practice of belief; belief in a power that has a strong influence over your life, world affairs, and natural disasters; and degree of helpfulness of a power to cope with personal events) (King et al., 1995) At baseline, 16% reported no R/S belief, 41% reported low intensity of belief, and 43% reported strong belief.	Core bereavement items scale (Burnett et al., 1997)	Stronger religious and spiritual belief related to steady and quicker resolution of grief. Low intensity of belief related to slower resolution for first 9 months and quicker resolution by 14. No belief related to temporary resolution at 9 months and return of symptoms at 14 months. Controlled for sex, age, pre-loss anxiety and depression, locus of control, social isolation, and closeness to patient.	Longitudinal and prospective: survey (4x), pre-loss and 1, 9 and 14 months post-loss

Wijngaards-de Meij et al., 2005 219 Dutch parents, married couples; age range=26-68, M age=42.2; loss to illness or disorder, accident, suicide, homicide, SIDS, neonatal death or stillbirth; time post-loss varied	Religious affiliation: religious vs. nonreligious	Inventory of Complicated Grief (Prigerson et al., 1995), Dutch version (Dijkstra, 2000); the depression subscale of the Symptom Checklist-90 (Derogatis, 1977), Dutch version (Arrindell & Ettema, 1986)	Considering oneself religious predicted higher levels of depression but was not related to grief. Controlled for parent and family demographics (e.g. gender, age, number of children) and circumstances of the loss (e.g. cause and expectedness).	Longitudinal: questionnaire (3x), 6, 13, and 20 months post-loss
Wyatt, 1999 124 adult caregivers, 75% women who experienced loss of spouse; time post-loss=within 3 months; loss of loved one to cancer	11-item measure of spirituality (e.g. "I accept the mysteries of life and death," "I pray or meditate")	CES-D (Radloff & Locke, 1986); 10 items measuring positive outlook; 13 items measuring health service utilization (including consulting with minister, priest, or rabbi); and 6 items measuring self-assessed health status	Greater spirituality was correlated with less depression and with more positive outlook, and was not related to health service utilization or health status.	Cross-sectional: interview (1x)
Yamamoto et al., 1969 20 Japanese widows; M age=38, age range=24-52; loss of husband to car accident; M time post-loss=1.5 months; Buddhist (n=13), no affiliation (n=6), Shinto (n=1); almost all (n=18) had butsudan or kamidana (family altar) in home	Religious affiliation; presence of the family altar	Sense of presence of the deceased; depression or anxiety, insomnia, difficulty accepting loss, blames others, attempts to escape reminders of deceased, apathy, blames self	Compared to the unaffiliated group, the religious group reported less apathy, difficulty accepting the loss, and blame of others, though more depression or anxiety, insomnia, and attempts to escape reminders of the deceased. Compared to the group with altars, the group without altars in the home showed poorer adjustment on all measures except insomnia.	Cross-sectional: interview (1x)

Note. (1x), (2x), etc. refers to the number of times the interview, questionnaire, or survey was conducted with the sample; "M age" designates the mean age in years of the participants in the sample; "age range=" refers to the range in years of the ages of the participants in the sample; "M time post-loss" designates mean time (in the units given) since the death for the participants in the sample; "time post-loss=" refers to the range of time (in the units given) since the death for the participants in the sample.